STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

MEMORANDUM

TO: All Disposable Medical Supply Providers

FROM: Jane Sacco, Division Chief
Division of Community Support Services

DATE: April 2, 2003

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All requests for diapers and underpads should be billed direct under the new direct bill allowable (See Transmittal #53). Should the request for disposable pants and underpads require more than the direct bill allowable or if the recipient is under age three, then you must forward the recipient's request to this Department on a DHMH 4527 along with the appropriate medical documentation.

To assist you, please note below the clarification provided by this Department of the criteria for submitting requests for disposable pants and underpads:

Disposable pants and underpads for recipients under age three or in excess of the direct bill limit will be preauthorized only when medically necessary and appropriate. For recipients requiring more than 240 incontinence pants or 135 pads in a 30-day period, the recipient's medical condition must be such that the direct bill limit is insufficient.

For recipients under age three:

- Authorization of disposable pants and pads for recipients under age three will be authorized when the recipient requires care for a disease that is transmitted primarily by blood/blood products and/or body fluids, or
- For recipients under age three, a medical condition must exist that necessitates the provision of disposable pants and underpads beyond that which would be considered age-appropriate.

For recipients needing more than the direct bill allowable:

- The provider must demonstrate the medical necessity and appropriateness for the additional supplies. The request should include the following on the prescriber's order:
- The specific medical need for more than 240 disposable pants and 135 underpads per month.
- The approximate daily urinal voidance.

For all requests beyond the direct bill allowable, current physician orders must be maintained per 42 CFR §440.70. Also, indicate if the provision of these supplies will prevent institutionalization and if the recipient is incontinent.

Questions concerning this communication should be directed to a Staff Specialist within the Division of Community Support Services at 410-767-1739.

State of Maryland

MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
OXYGEN SUPPLY TRANSMITTAL NO. 21
MEDICAL SUPPLY TRANSMITTAL NO. 46

October 27, 1995

TO: Oxygen and Related Respiratory Equipment Providers
Disposable Medical Supplies/Durable Medical Equipment Providers

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

NOTE: Please ensure that appropriate staff members in your organization are informed about the contents of this transmittal.

RE: Licensure of Home Medical Equipment Services Providers

As you know, any person or agency that functions as a Residential Service Agency must be licensed by the Department of Health and Mental Hygiene before providing any home health care. During the 1994 Session of the General Assembly, the scope of this requirement was broadened to include home medical equipment services providers. Therefore, as of October 1, 1994, under § 19-4A-01 of the Health-General Article, a person must be licensed through the Department's Office of Licensing and Certification Division as a Residential Service Agency before the person may provide home medical equipment services. These services include the delivery, installation, maintenance, replacement of, or instruction in the use of, medical equipment used by a sick or disabled individual in order to keep that individual from having to be cared for in an institutional setting.

The following types of medical equipment are covered under the law and will be included in regulations to be adopted at COMAR 10.07.05 Residential Service Agencies: oxygen and oxygen delivery systems, ventilators, respiratory disease management devices, electronic and computer-driven wheelchairs and seating systems, Apnea monitors, transcutaneous electrical nerve stimulators, low air loss cutaneous pressure management devices, sequential compression devices, neonatal home phototherapy

devices, feeding pumps, and electrically powered hospital beds. The regulations also establish a fee of $500 and the general standards and procedures for licensing providers of home medical equipment.

Requirements for licensure and providing home medical equipment are available through the Office of Licensing and Certification and will in the near future be incorporated into COMAR 10.09.12 Disposable Medical Supplies/Durable Medical Equipment and COMAR 10.09.18 Oxygen and Related Respiratory Equipment.

Questions regarding this transmittal should be directed to the Staff Specialist for Disposable Medical Supplies/Durable Medical Equipment and Oxygen by calling (410) 767-1739.

JMM:jcg

STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Medical Supply and Equipment Transmittal No. 50
Oxygen Transmittal No. 23
February 9, 2001

TO: Disposable Medical Supply/Durable Medical Equipment Providers
Oxygen Providers

FROM: Joseph Millstone, Executive Director
Office of Health Services

SUBJECT: Instructions for the DHMH Preauthorization Request Form (DHMH 4527)

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal

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Attached please find the instructions to complete the Maryland Medical Assistance Program's Preauthorization Request Form. The purpose of this issuance is to assist providers in properly completing requests for durable medical equipment, disposable medical supplies, oxygen and oxygen related equipment. Following these step-by-step instructions will facilitate timely processing of preauthorization requests by the Medicaid Program. Please distribute these instructions immediately upon receipt of this transmittal. Thank you.

If you have questions pertaining to the completion of the DHMH 4527, you may reach the Division of Community Support Services at 410-767-1739.

JM/lsc
Attachments

Instructions for completing the Preauthorization Request Form for Disposable Medical Supplies, Durable Medical Equipment and Oxygen and Respiratory Equipment (DHMH 4527)

The header above Section I assists DHMH staff to properly categorize and process your request. Proper categorization facilitates timely processing. These categories include Durable Medical Equipment, Disposable Medical Supplies and Oxygen and Related Respiratory Equipment. Also, please specify whether this is an initial request or a follow-up request. If you are requesting items from more than one category, please use a separate form for each category. (ex. Requests for diapers should be written on a separate form when also requesting oxygen equipment)

Section I – Recipient Information

Section I identifies the intended recipient of the requested supplies or equipment. Please complete this section in its entirety ensuring the name of the recipient matches the data you provide. To make sure you are identifying the correct Medicaid fee-for-service eligible recipient, it is essential for you to consistently use the Eligibility Verification System (Provider Relations 410-767-5340). If the recipient identified is not eligible for the Medicaid services requested, the preauthorization cannot be approved.

Section II – Preauthorization General Information

Section II identifies the provider offering to supply the equipment or supplies. Each portion of this section is equally important. An accurate provider number, name and address ensure payment to the correct provider. Identification of a contact person by name and telephone number are helpful to DHMH staff when additional information is required from the rendering provider.

Note: It is important that the "pay to" or rendering provider is enrolled as a Maryland Medicaid Provider. If the provider is not enrolled with Maryland Medicaid, the preauthorization request cannot be approved. Should the "pay to" provider wish to initiate the enrollment process, they must contact Provider Enrollment at 410-767-5340.

Section III – Additional Preauthorization Information

The prescribing provider's number, name, address and telephone number must be submitted. Your request cannot be approved if the request form is not signed and dated by the ordering physician; or if a copy of the physician's signed order/prescription is not attached to the DHMH 4527. Additionally, the recipient's diagnosis, prognosis and the medical justification for the requested item (s) must be provided. When completing the "medical justification", the goal is simply to explain why the requested item(s) is needed and why the Medicaid Program should reimburse for services. The simplest way to do so is to relate the need to the information provided immediately above in "Diagnosis and Present Condition". When the requested item(s) replaces an existing item(s) the rationale and justification for the replacement needs to be explained on the DHMH 4527 or on the prescribing provider's letterhead. The physician must also include the date he/she has last seen the recipient.

Section IV – Preauthorization Line Item Information

Clearly identifying the item(s) for which preauthorization is requested helps to expedite a timely response from the Medicaid Program. Items should not be submitted with a miscellaneous HCPCS Procedure Code when one has been assigned. Submission of such could delay the response to a request. When complete and accurate information is not provided, the preauthorization form cannot be approved with the undesirable result of delaying consumer receipt of requested items. The header above Section IV identifies the location of the Medicaid recipient. If the patient is in a nursing home or hospital, he/she is not eligible to receive durable medical equipment or disposable medical supplies through the fee for service program. All services will be provided by the inpatient facility. If the recipient is scheduled to be discharged to his/her home and will need medical equipment and/or supplies to prevent re-institutionalization, please provide the date of the impending discharge and a copy of the signed discharge order. Please complete "Requested Amount" section with the amount your company would like to be reimbursed.

Section V – Detailed Item Information

Section V is completed for requests of customized items or items requiring individual consideration. For customized items, it is necessary to attach a specification/product sheet from the manufacturer, including the manufacturer's price, address, telephone number and provider number. It is also very important to fill-in the "Single Unit Price" section with the manufacturer's suggested retail price.

Notes:

- Search your files carefully for duplicate requests. Duplicate requests will be denied.
- Home assessments for mobility equipment must accompany the DHMH 4527, no exceptions.

Completed forms are to be mailed to:

Office of Operations and Eligibility
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

Resubmitted preauthorizations are to be mailed to:

Department of Health and Mental Hygiene
Division of Community Support Services
201 West Preston Street, Room 130
Baltimore, Maryland 21201

If you have any questions pertaining to the completion of the DHMH 4527, or if you require additional training you may reach the Division of Community Support Services at 410-767-1739.

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM

☐ DURABLE MEDICAL EQUIPMENT ☐ DISPOSABLE MEDICAL SUPPLIES
☐ OXYGEN & RELATED RESPIRATORY EQUIPMENT ☐ INITIAL REQUEST ☐ FOLLOW-UP

SECTION I - Recipient Information

Medicaid Number | | | | | | | | | | | | |

Name _____ DOB _____ Sex ___ Telephone (___) _____
(Last) First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number | | | | | | | | | |

Name _____

Address _____

Request Date _____ Contact _____ Telephone (___)_____

SECTION III - Additional Preauthorization Information

Prescribing Provider | | | | | | | | | |

EPSDT (Y/N)? ___ PDN (Y/N) ___ WAIVER (Y/N)____

Name _____ Rental Extension (Y/N)? ___

Address _____ Initial Date of Rental __/__/__

_____ Period of Time Required _____

If Oxygen/Respiratory Equipment
Initial Request Recertification

Telephone (___)_____

Physician's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN:
Diagnosis and Present Physical Condition _____

_____

Medical Justification _____

_____

Prognosis _____

Date last seen by Physician: _____

* If Oxygen request, please attach pertinent laboratory/pulmonary function test results: ABG's, sleep apnea studies or PFT's

* If Oxygen request, duration and liter flow per minute; for 02 recertification, please resubmit ABG's on room air by: _____

AUTHORIZATION NUMBER | | | | | | | | | | | | |

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DOCUMENT CONTROL NUMBER
(STAMP HERE)

COMPLETE REVERSE SIDE

DHMH 4527 REV.3/97

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM

Patient Location: Home ___ Nursing Home ___ Hospital In-Patient___ Discharge Date ___/___/___

SECTION IV - Preauthorization Line Item Information

	NAME OF ITEM	PROCEDURE CODE	DATES OF SERVICE FROM	DATES OF SERVICE THRU	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
1.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____
2.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____
3.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____
4.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____
5.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____
6.	_____	____	__/__/__	__/__/__	____	$_____	_____	$ _____

SECTION V - DETAILED ITEM Information

	MFGR	MODEL/PRODUCT NUMBER	SINGLE UNIT PRICE	AMT PER PKG (IF DMS)
1.	_____	_____	$ _____	_____
2.	_____	_____	$ _____	_____
3.	_____	_____	$ _____	_____
4.	_____	_____	$ _____	_____
5.	_____	_____	$ _____	_____
6.	_____	_____	$ _____	_____

All equipment purchased by the Department for the patient's use remains the property of the Department of Health and Mental Hygiene. Patient is requested to contact the Medical Assistance Program when equipment is no longer needed.

Item Received by _____ Date _____

Signature of Recipient or his Agent